

# PROVIDER RE-APPROVAL COMPLETION GUIDE

## PROVIDER RE-APPROVAL

The provider re-approval process is designed to validate that a provider maintains policies, procedures and systems that ensure the needs of consumers are met according to Individualized Support Plans, Behavioral Support Plans and Risk Plans. Providers must substantiate that their systems (i.e., policies, procedures, protocols, staff training, etc.), are designed to address quality improvement and all processes are aligned to offer programs with health, safety and welfare at their core. The Bureau of Quality Improvement Services (BQIS) will utilize Provider Review Profile data, the completed Re-Approval Assessment, and any requested addenda to justify a recommendation of a re-approval term of 6, 12, or 36 months.

## DOCUMENTS

To perform a thorough fact based review, a provider-specific report has been developed and is titled the **Provider Review Profile (PRP)** (Attachment D). Once the provider has reviewed and analyzed its PRP, the provider then completes the **Re-Approval Assessment** (Attachment F) document.

### PROVIDER REVIEW PROFILE (PRP) – ATTACHMENT D

The PRP is a data-driven report that allows the provider to assess its organization's data against a benchmark of relatively similar providers (e.g. client count, Algo levels). Analyzing this data is pivotal in reviewing the provider's performance. The PRP is structured to provide data in multiple risk areas.

The first page of the PRP is a worksheet which contains the raw data for the provider. The next section contains risk area data which includes complaints, general incident data, incident processing data, data for abuse, neglect and exploitation, behavioral data, and medical data. The final section of the PRP is a technical guide that includes the calculations for each of the risk areas. For each of the risk areas, the provider should analyze the raw data to determine one or more reasons for being out of the expected range (above or below). Attachment E in the re-approval documents is an Excel spreadsheet of all incident reports for the timeframe in the PRP. This data should be an essential tool in conducting the data analysis.

### RE-APPROVAL ASSESSMENT – ATTACHMENT F

The Re-Approval Assessment is designed to detail the data analysis conducted, convey organizational processes, demonstrate compliance, and identify areas of improvement. There are six sections. The first four sections are linked to the risk areas in the PRP: complaints and incident data; incident processing and ANE data; behavioral data; and medication and medical data.

For each risk area identified as above or below the expected range, the provider will explain the reason for being out of expected range. Data that falls *below the expected range* or *above the expected range* may be indicative of issues within your organization's operational systems. Data that is above or below that of your peer group is not where an organization's data should fall and requires a full analysis of the data to explain the results. A review of the data with a quantitative analysis may provide the information to assist in determining the root cause. The results of this analysis are documented on the Re-Approval Assessment. For the re-approval process, providers should consider how their respective PRP data is reflective of quantitative and qualitative data: quantitative numbers are indicative of measureable facts, but the qualitative data is suggestive of what methods your organization uses, and whether or not they are working to deliver outcomes, your organization expects. For data that falls *above the expected range*, a **quantitative analysis is expected** to explain why the provider is out of the expected range

*Tips: When documenting the reasons for the variation from the norm (being above or below the expected range), consider issues such as individual-specific data that may be affecting your rates (e.g., repeat incidents attributed to a few consumers). Detail if there is evidence to suggest data is trending in the right direction (i.e., showing improvement).*

Once the data has been analyzed, the provider is asked a series of questions to assess how performance in these categories is monitored and how service level improvements are made based on the data. The remaining two sections of the Re-Approval Assessment are focused on the broader subject of providing quality care and services.

## DOCUMENT SUBMISSION

The completed Re-Approval Assessment is due on or before the due date noted on the cover page and must be submitted electronically to BQIS at [BQISReporting@fssa.in.gov](mailto:BQISReporting@fssa.in.gov). When submitting this document, the provider may also attach to the email (as separate documents and labeled as exhibits) copies of supporting documents that will aid in the review of the provider's systems and processes; **however, these do not take the place of responding to the Re-approval Assessment questions.** All supporting documents must be referenced as exhibits within the Re-Approval Assessment. Once submitted, BQIS will review the completed Re-Approval Assessment. Providers may be asked to meet in person or via telephone for the purpose of BQIS explaining any clarifying questions that require further explanation/detail by the provider. The provider through the submission of a re-approval addendum will submit the clarifying information. *Note: Failure to submit a written Re-Approval Assessment by the established due date will eliminate the opportunity for provider clarification. Additionally, it may result in the provider receiving a re-approval term that is not preferred and/or a referral to the DDRS Sanctions Committee.*